Safer Lambeth's

Domestic Homicide Review 001

Overview Report

Report produced by Jane Ashman - Independent Chair & Author

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Safer Lambeth Partnership

Contents

1. Introduction

1.1. Ms Z was found dead at the home of Mr L on 07.01.13. Mr L was arrested on 09.01.13 and charged with her murder on 12.01.13. Prior to the murder Ms Z and Mr L were understood to be in a relationship and that Ms Z was living at his flat. The Police formally notified Safer Lambeth that the death was domestic homicide related and on 15.02.13 the decision was taken to conduct a Domestic Homicide Review in accordance with Section 9 (3) of the Domestic Violence, Crime and Victims Act (2004). The Home Office was also notified on that date.

1.2.The Terms of Reference for the review are attached as Appendix 1. It will be noted that in the time she had been in the Country Ms Z had had almost no contact with any of the statutory or voluntary agencies forming the panel or contacted on behalf of the panel. Mr L was known to various agencies in relation to domestic violence against 2 women from previous relationships (Ms X and Ms Y). Personal information specific to those 2 women has not been sought, but information about contacts, incidents and services as they relate to incidents of violence by Mr L have and inform the substance of the report.

1.3.The Coroner has been informed that a DHR is being undertaken.

1.4.A Mental Health Independent Homicide Review has not been commissioned.

1.5.The Domestic Homicide Review Panel comprised:

Jane Ashman	JA	Independent Chair
Jade Holvey	JH	London Borough of Lambeth (LBL)- Officer Support
Ruksana Mannan	RM	LBL – Officer Support
Adam Kerr	AK	London Probation Trust
Claire Moxon	CM	Metropolitan Police (MPS)
Timothy Spratt	TS	MPS – Specialist Crime Review Group
Paul Gardener	PG	MPS – SCRG
Martin Baggaley	MB	South London and Maudsley NHS Foundation Trust

		(SLaM)
Helen Charlesworth-May	HCM	Strategic Commissioning, LBL and Health
Cedric Boston	CB	Lambeth Living (LL) - Housing Provider
Ann Corbett	AC	LBL
Nicole Jacobs	NJ	Refuge / Gaia

1.6. The Independent Chair and Author was commissioned to undertake the review following a tendering process that included 2 references and she has no employment or personal connections with any of the partners of Safer Lambeth (the Commissioners).

1.7. Internal Management Reviews were received from:

Metropolitan Police Service: Lambeth
Lambeth Living
Lambeth Housing Options
London Probation Trust
Gaia/Refuge
SLaM
Single Homeless Project

1.8. IMRs were requested from but refused by:

Job Centre Plus

1.9. IMRs were requested and though not provided, sufficient information was received to decide not to pursue further, from the following agencies:

HMP Hewell
Primary Care (GP)

1.10. Information (not IMRs due to the limitation of their involvement) was requested from:

Hampshire Police Service
Essex Police Service
Lambeth Noise Enforcement Team
London Ambulance Service

Guy's & St Thomas' NHS Foundation Trust

Kings College Hospital NHS Foundation Trust

Family Mosaic Service

Care UK (Mental Health providers to HMP Belmarsh)

Adult & Community Services -MARAC Notes

1.11.Initial information was also requested from:

Thames Reach

Mosaic Clubhouse

CRI

SORT

but they told the review they had no knowledge of either the victim or perpetrator.

2. The Facts

2.1.Family Composition:

Mr Z senior	Father
Mrs Z	Mother
Mr Z	Brother
Ms Z	Victim

2.2.Ms Z aged 23 years, a Russian national, visited the United Kingdom in 2011 and again in 2012. Whilst visiting in the summer of 2012 she met Mr L and their relationship began. On 10.12.2012 Ms Z returned to the United Kingdom on a visitor's visa. On her return to the UK she was unable to find Mr L as he was in prison for breaching a restraining order in relation to a previous partner. He was released from HMP Belmarsh on 12.12.2012 and they stayed together at his flat which was registered to Mr L and there were no other adults or children living there.

2.3.Ms Z had known Mr L for approximately 6 months and had been living with him on this occasion (it is not known if she stayed with him during her summer visit) for less than 3 weeks.

2.4.Ms Z had a mother, father and brother living in Russia, she had no children.

2.5.On 06.01.13 Mr L bumped into a mutual friend and informed him the relationship was over and he hadn't seen Ms Z for a month. After speaking by phone to Ms Z's brother in Russia the mutual friend reported her missing to the Police on 06.01.13. The Police forced entry to Mr L's flat early on 07.01.13 and found Ms Z's body in the lounge, she had been dead for a period of time and her body had been severely assaulted.

2.6.A Post Mortem was held on 08.01.13 and the preliminary conclusion was that the death was caused by blunt trauma to her head, face and neck. She had a crushed thyroid cartilage indicating that she may also have been strangled.

2.7.Mr L was arrested in Kent on 09.01.13 after being stopped in response to a burglary and after a check on the Police National Computer (PNC) showed he was wanted on suspicion of murder. He was charged with the murder on 12.01.13 and pleaded guilty to manslaughter on 18.11.13. He was ordered to serve a minimum term of 7 years and three months. The Judge also made a hospital limitation order under Section 45a of the Mental Health Act, meaning he will be detained at a secure hospital for treatment but if deemed well enough to leave hospital before his minimum term of detention is complete he will be transferred to a prison for the remainder of his sentence.

3. Narrative Chronology of Events

3.1.Mr L was picked up on a Section 136 Mental Health Act (MHA) 1983[1] having been found wandering at Gatwick Airport, seeming confused and hearing voices. He was admitted to the Lambeth Early Onset (LEO) unit of SLaM on 18.08.2005 and after stabilising and responding to medication he was discharged on 12.10.05.

[1] If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety

3.2. On 28.11.05 Hampshire Police were summoned to a domestic incident where Mr L was arrested and interviewed under caution for an assault on his mother who is said to have intervened in an argument between her 2 sons, she was struck with a meat tenderiser. No further action was taken, as his mother did not wish to substantiate the allegation.

3.3. On 18.03.06 Essex Police were called to the University where Mr L had been staying with Ms X who was a student there. He had started an argument and Ms X asked him to leave, college security had dealt with it and Mr L had left before the Police arrived. She was offered a "help leaflet" which she declined and no allegations of offences were made. The incident was recorded on PROtect[2] and there was no further action.

3.4. On 04.04.06 Mr L presented as homeless to Lambeth Housing Services, initially he was refused accommodation. He started contact with the Lambeth Early Onset Service (LEO) on 21.04.06 who provided community treatment and support to help him be accepted as statutorily homeless. He became more thought disordered over the following weeks including on 05.05.06 claiming to have become a Muslim the day before and attributing some of his thoughts of persecution to this. He was technically accepted as homeless on 27.07.06 though because he failed an appointment the next day he was "de-authorised for housing". On 03.07.06 he again became an inpatient with SLaM and was eventually discharged on 25.07.06. By then he had been offered temporary bed and breakfast (B&B) accommodation in Lewisham through Lambeth Council whist his homelessness status was reviewed. During this time he was reported as being supported by his girlfriend Ms X.

3.5. Mr L then had a stable period whist in B&B, co-operating with the LEO team and his medication. On 18.09.06 he failed an appointment with his LEO psychiatrist and didn't respond to a duty officer contact the next day. There is no other LEO team note until 31.10.06, which is after a second encounter with the Essex Police on 25.10.06 when he was cautioned for shoplifting; this was his first convicted offence. When reviewed by a LEO doctor on the 31.10.06, he had some presenting symptoms and admitted he had not been taking his medication

[2] An Essex Police data base re Domestic Violence

for a number of weeks and to some cannabis use. Attempts by the LEO team to contact Mr L in November failed.

3.6. On 04.12.06 Essex Police were called to a domestic incident at an address in Colchester. Ms X and Mr L had argued and Mr L kicked Ms X in the stomach and punched her in the back and leg. The incident was recorded by the attending officer as a crime of common assault by a stranger and filed without Mr L's name being recorded. The relevant paperwork was completed and filed on PROtect.

3.7. On 06.12.06 Mr L attended the LEO team base but did not wait until he could be seen by a clinician. He was seen on 13.12.06, didn't appear to have psychotic symptoms but was "flat" with some psychomotor retardation, he hadn't been taking medication for a number of weeks and was still living in B&B.

3.8. The LEO team made unsuccessful attempts to contact Mr L during the rest of December and January. He was reviewed by the Consultant on 02.01.07 in his absence, where it was noted that he was "poorly engaged" and that he was "doing very little and not making an effective recovery". He was seen irregularly though efforts were made to keep in touch even though he had been out of the team's geographical area for some months. They were looking to transfer him to a more local service but Mr L had not registered with a GP and was still in temporary accommodation so they continued to support him.

3.9. On 12.03.07 Mr L was offered permanent accommodation back in Lambeth, he gave his next of kin as his mother living in Southampton, but no address was given. He moved in on 19.03.07. This address enabled the LEO team to continue to support him.

3.10. At a "settling in" visit on 02.04.07 Mr L told a housing officer that he had mental health problems and had been hearing voices, the housing officer made a referral for tenancy support. On 10.04.07 a near neighbour made a complaint about "nuisance" from Mr L's flat, no further details are recorded.

3.11. On 11.04.07 the LEO team received a call from a police constable in Kennington who had arrested Mr L on suspicion of assault, he was presenting bizarrely and she wondered about his mental health history. He was subsequently admitted to

hospital under Section 2 (Mental Health Act 1983)[3] where he remained until his eventual discharge on 12.06.07. with aftercare from the LEO team.

3.12. During his time in hospital Mr L was at times very unwell with often aggressive, paranoid and chaotic behaviour. He had stored knives under his bed to "protect himself" and acquired other implements that could be used such as forks and razors. His admission included a period in the Psychiatric Intensive Care Unit (PICU). During his stay he had a large number of visitors including his mother and a woman described variably as his "ex girlfriend" and his "girlfriend" on one occasion becoming very aggressive when she visited. He also believed that the man he had hit in the cafe (which led to his admission) had caused the breakdown in his relationship. He displayed very mixed emotions towards the (ex) girlfriend including "I think she is a witch" and "my girlfriend was a very bad woman, she wanted to poison me. She wanted gay man to fuck me in my ass, sorry for my language. She does voodoo magic. Magic works because it says so in the Q'uran". On another occasion it is recorded that: "He says that he is in love with a woman outside. Says that he was about to marry her that she was his soul mate". When he was reviewed by the Consultant on 14.05.07 he initiated a Section 3[4] assessment noting: "Remains unwell and not engaging. At serious risk of violence if discharges himself." Ultimately the assessment for Section 3 was halted as Mr L began to improve.

3.13. Following discharge on 12.06.07 the LEO team provided information to Lambeth Housing indicating that Mr L had a high level of violence (including possession of knives) when unwell. He was referred to the Family Mosaic Housing Association (specialist tenancy support for people with mental ill-health) on 28.06.07.

3.14. Mr L was accepted for tenancy support and initial contact was made and a meeting with Mr L held on 17.07.07 where an assessment and support plan were agreed. Because of an impending holiday this was to commence mid- August. However from that point he did not re-engage and after several failed appointments Mr L said on 20.09.07 that he no longer wanted or needed their help. The case was formally closed on 05.11.07.

[3] Section 2 (s2) allows a person to be admitted to hospital for an assessment of their mental health and receive any necessary treatment for up to 28 days.
[4] Section 3 (s3) allows a person to be admitted to hospital for treatment. It must be necessary for the person's health and safety or for the protection of other people that the person receives treatment and it cannot be provided unless (s)he is detained in hospital.

3.15.At a clinical review with the LEO Consultant Psychiatrist on 13.07.07 Mr L informed the doctor that he was living with his girlfriend at his flat and was about to go to Portugal for 2 weeks holiday. The same doctor reviewed him a month later 10.08.07 when he was still reported to be living with his girlfriend, but also that he was bored. The doctor had some concerns he was becoming depressed "Given the mood component to [Mr L's] psychotic illness I would like to keep a watchful eye in the next few weeks to make sure he is not becoming depressed." This doctor had been one of the doctors completing the section 2 in April.

3.16.On 13.09.07 the Police were called to Mr L's address by a neighbour, who had heard sounds of a domestic disturbance. Ms X and Mr L were present and no criminal allegations were made by either party.

3.17.Over the following 10 weeks Mr L engaged intermittently with his mental health team and was erratic with his medication. He informed them his girlfriend was studying in abroadSpain; this caused staff some concern as it increased Mr L's potential for isolation. By 04.12.07 he was causing concern and displaying overt paranoid symptoms particularly in relation to a neighbour. The process was started to assess for a Section 3 but shortly after, better contact with the team was established, the assessment for Section 3 stopped and relatively close contact was maintained. On 27.12.07 Mr L visited the LEO office and was recorded as having his girlfriend with him.

3.18.On 09.02.08 the Police were called to Mr L's flat about a domestic incident. Mr L had become angry about a telephone and began smashing property in the flat cutting his hand in the process. He was taken by ambulance to St Georges Hospital. No criminal offences were disclosed.

3.19.Mr L attended the LEO offices on 11.02.08 for help with a GP registration form, scratches to his forehead and hand were observed but he would not say how they had happened. His contact with the team for the following 6 months was largely on Mr L's terms. He missed planned appointments but called unplanned for his medication and particularly when he wanted assistance with practical things such as his freedom pass application or to use the phone to contact Lambeth Living over repairs.

3.20. On 24.08.08 the Police were called to Ms X's address she and Mr L were outside and Ms X was tearful. They both reported an argument that had got out of hand and apologised for involving the Police. The Police record states they were separated for interview but individually, each was reluctant to speak to the police. Mr L is recorded as voluntarily returning to his own flat.

3.21. On 05.09.08 Mr L made an unplanned visit to the LEO offices dressed in an Islamic kameez and explaining he had converted to Islam 2 years previously. (Whilst very ill as an inpatient in 2007 he had believed he was Muslim and had been born a Muslim called Abdul Rahman). He denied any relapse symptoms, he used the phone re a faulty light, and no other reason for his visit was recorded.

3.22. The following day (06.09.08) the Police were called again to Ms X's address Mr L had forced his way in through the back door to argue with her about the breakup of their relationship, he had smashed her phone and held a knife against his throat whilst demanding to know why she had ended their relationship. He was arrested at the premises and removed, at interview he admitted kicking open the door but "only so he could sleep with [Ms X]." Ms X was reluctant to pursue a complaint, as she believed he needed mental health treatment. He was given an adult caution for criminal damage.

3.23. On 11.09.08 the Police attended Mr L's address. Ms X explained that their relationship had been splitting up over the past two to three weeks. She stated that they had met the previous day and whilst sitting in her car he had become angry and kicked the windscreen causing a crack. This was not reported to police at the time as he had agreed to repair the damage. She had returned to his address on this day in order that the windscreen could be repaired. An argument had ensued and he pushed her onto a mattress and head butted her. He had then left the address got into her car and drove it around the car park. She was then able to telephone police and Mr L was arrested for assault and criminal damage. In interview, he denied the allegations and he was bailed. The matter was discontinued by the Crown Prosecution Service (CPS). The Police appealed this decision, it was reviewed by a different CPS solicitor and the decision was upheld and the matter discontinued on "public interest grounds". (see below 3.25).

3.24.On 21.09.08 the Police were again called to Mr L's address. Ms X and Mr L were sitting in her vehicle outside his address discussing their relationship. Ms X had wanted to terminate their relationship, as she believed Mr L had cheated on her. Whilst sitting in the vehicle she tried calling a friend, Mr L believed that she was calling the police and tried to grab the phone. He then pushed her and squashed her against the driver's door and head butted her in her cheek. After the assault she was scared of what else could happen and therefore agreed to go into his address to put ice on the swelling. Once inside the address he refused to let her leave. He became more aggressive and head butted kitchen units. After a couple of hours following a telephone conversation with her friend she was able to leave. She was followed by Mr L but whilst in her car managed to telephone the police. She had bruising and swelling to her cheek and he was arrested for assault and interviewed with an appropriate adult. He made no comment during his interview. He was charged with common assault and remanded in police custody to Camberwell Magistrates Court where he was bailed until 14.10.08.

3.25.By the time the CPS reviewed the police appeal on the incident of 11.09.08, Mr L had been convicted of a different assault on the same victim. This assault had occurred on 21/09/2008 (as detailed above); this had taken place after the incident being reviewed. The following remarks were recorded by the CPS reviewing lawyer - 'Based on the level of assault I do not consider that it is in the public interest to proceed to charge in this case based on the fact that [Mr L] has been convicted of a subsequent assault on the same victim. Had this matter proceeded at the same time I do not see any likelihood of an increase on sentence. As the matter will not proceed on PI grounds the matter can be used as bad character for any future incidents'.

3.26.Lambeth Police referred Ms X to the Refuge's Independent Domestic Violence Advocacy (IDVA) service on 24.09.08 in relation to the assault by Mr L on Ms X that took place on 21.09.08. The Refuge IMR shows this as having taken place on 23.09.08 but the description confirms this is the same incident and a clerical error is assumed. The refuge established contact the same day as the referral.

3.27.The pre-sentence report prepared for the hearing for the assault on Ms X on 21/09/2008, assessed his risk of serious harm towards his partner as "medium" and risk of reconviction within 12 months as "low". These were made using the

standard Probation risk assessment tools of Offender Assessment System (OASys) and Offender Group Reconviction Scale. The report did acknowledge concerns re Mr L's minimising of the offence and putting the blame for his anger on his victim and proposed how these could be addressed in a community order.

3.28. The next contact with the LEO team (since 05.09.08) was on 29.09.08 when Mr L's care co-ordinator saw him by chance. He talked of the "physical altercation" and impending court hearing, quickly said it was nothing to do with his illness but blamed the victim who he said "would go out clubbing" and would "return home late at night intoxicated and he would be at home worrying about her". The following day an Appropriate Adult form was faxed to the Team detailing Mr L's arrest and charges. Mr L was clinically reviewed by the Team's Specialist Registrar (SpR) on 09.10.08. The notes of this session summarise much of his psychiatric history, they also acknowledge the assault and forthcoming court appearance and say that Mr L is "clear in his mind that this incident did not relate to any symptoms of mental illness, and may be explained as an episode of domestic violence". It is noted that the Team has been offering follow up for more than the expected 2 years and that transfer to the South West Recovery and Treatment Team (SWT) should be effected.

3.29. Mr L appeared at Camberwell Green Magistrates' Court on 14.10.08 and was sentenced to a 2 year community order subject to probation supervision, 120 hours of unpaid work and to participate in an Integrated Domestic Violence Programme (IDAP). He was designated a Tier 3[5] offender, that is a case presenting a medium to high risk; requiring a high level of integrated supervision; where personal change is the priority; where the offender is vulnerable; and where mishandling could have serious consequences. The plan was to:

- Refer FL to probation's ETE (Employment, Training and Education) officer if required;
- Check monthly with police / local Community Safety Unit for intelligence updates;

[5] Tiering is part of the NOMS Offender Management Model. It provides a nationally consistent way of giving operational effect to two of the principles in the Offender Management Model – "resources follow risk" and "least necessary1". It factors together the main risks, needs and complexities which drive the minimum necessary resourceallocation for cases and breaks the whole offender caseload into four tiers. See also Probation Circular PC08/2008 – NATIONAL RULES FOR TIERING CASES AND ASSOCIATED GUIDANCE

- Liaise with the WSO (Women's Support Officer) re information / support for the victim;
- Refer FL to MAPPA Category 2, Level 2 to support exchanges of information; and
- Maintain contact with the mental health team treating FL.

3.30. The Refuge's IDVA attended court and contacted Ms X to inform her of the outcome on the same day. The following day a Multi Agency Risk Assessment Conference (MARAC) meeting was held in relation to Ms X as the Police contacts had reached the threshold for MARAC consideration and appropriate actions agreed were:

> [Lambeth Police] to liaise with Crown Prosecution Service regarding prosecution of outstanding criminal case.
>
> [London Probation] to advise supervising officer that case is subject to Lambeth MARAC and to highlight domestic violence risk concerns.
>
> [Refuge IDVA] to provide support to victim.
>
> [Refuge IDVA] to liaise with [London Probation] with regards to providing a support service to victim
>
> [Lambeth Police] to put special scheme on address.
>
> [Lambeth Police] to alert safer neighbourhood team.

3.31. On 21.10.08 Essex Police were called to the University Campus by a member of staff reporting a man attacking a woman in a car park, who it transpired were Ms X and Mr L who during an argument had grabbed Ms L causing scratches to her neck then punched and smashed the window of her car. Mr L was given a caution for a section 39[6] assault and criminal damage. According to the Essex custody record this was given "with the agreement of [Ms X]". The note does not state under what condition this "agreement" was sought.

3.32. The following day on 22.10.08 the IDVA made a failed follow up call to Ms X and on 27.10.08 a successful contact, where Ms X stated she was fine, at University in Essex, did not need a non-molestation order and had not been contacted by Mr L. She was advised that the refuge would be closing the case and she said that she was fine with this.

[6] Section 39 of the Criminal Justice Act1988 provides: Common assault and battery shall be summary offences and a person guilty of either of them shall be liable to a fine not exceeding level 5 on the standard scale, to imprisonment for a term not exceeding six months, or to both.

3.33. Between 16.10.08 and 12.11.08 Mr L had erratic contact with the LEO team not attending planned visits and calling unplanned for practical help, he had a bailiff's notice for a £3000 debt, apparently relating to previous rent arrears. His attendance at his probation appointments was also erratic at this time with his Offender Manager (OM1) noting 4 missed sessions.

3.34. Mr L visited the LEO offices on 24.11.08 agitated and stating he had received a letter from Probation saying he was to return to court as he was in breach of his order having failed to attend his community service. He was observed to be showing signs of relapse (arousal/agitation) and an appointment was made to see the doctor the following week. A clinical review between team members the next day discussed Mr L's behaviour and possible relapse.

3.35. OM1 noted similar erratic behaviour and at an interview on 25.11.08 when informing him that he had breached his community order conditions, he blamed his "girlfriend" for keeping him up at night, accused her of "stealing his sperm" and made threats to hit/kill her. OM1 amended her risk of serious harm assessment to "high" as a consequence of that meeting. OM1 obtained details of his victim (Ms X) and passed these to the Women's Safety Officer (WSO) on 12.11.08. On 27.11.08 OM1 contacted the Police MARAC link officer at the Community Safety Unit (CSU) re her concerns for the Victim's safety and was told they had no current plans re Mr L but would pass her concerns to MARAC.

3.36. OM1 made contact with CC1 on 27.11.08 and shared her concerns. OM1 was concerned for Ms X's safety and also stated her intention for a "mental health requirement" to be attached to Mr L's order at the breach hearing. CC1 agreed to try and assess him that day, which after several attempts to contact Mr L he did, who agreed to attend the LEO base. As well as concerned about his debt he presented as "agitated, identifying his ex partner as the cause for his trouble - his admission in 2005, and his current probation order due to domestic violence. Described her as driving him mad, coming to his home or calling him all the time and reported frequent arguments. Feels she has stopped him getting employment, as currently he has to attend probation and community service limiting his chance to get paid work. Used expletives and derogatory descriptions of her throughout. Reports that he is no longer going to see her and he had to focus on the future." The notes state that he was strongly advised to avoid

contact with her and that there was a high risk of violence towards her if they remained in contact. Mr L was then seen together with the SpR who confirmed the clear signs of deterioration and possible signs that thoughts about Ms X were part of his paranoid delusional system.

3.37. On 28.11.08 CC1 contacted OM1 re the above and stated that the risks were too high for no action and that a mental health act assessment was to be initiated. OM1 also contacted the Police MARAC liaison officer again discussed concerns re risks to Ms X and recorded that she was told "there was action in hand to protect the victim".

3.38. Mr L was seen by a number of the LEO team over the next few days including the Consultant Psychiatrist who had known him since first referral to the LEO team. The on going concerns that he was relapsing remained, though his presentation was more controlled and less erratic, the Consultant raised a plan that involved contacting Ms X or her legal representative to not to have contact with him. To ascertain whether she had recently visited, as he had claimed and to check with the Police if they had been called by Mr L re Ms X, as he had also claimed. As a consequence the Mental Health Act assessment was suspended for a period both to monitor him and establish the collateral information.

3.39. OM1 began preparing Mr L for participation on IDAP on 09.12.08, he was described in this session as "emotional and angry towards ex-partner/victim. Did not like her mixed heritage." He had some but irregular contact with the LEO team failing planned appointments. A home visit was carried out by his CC1 on 19.12.08 due to concerns re his non-attendance, though at his flat Mr L only spoke from the window as he said someone was with him and he agreed to attend the LEO offices on the 22.12.08 to collect his medication, nothing remarkable was noted.

3.40. On 25.12.08 the Police were called to Mr L's premises, he and Ms X were spending Christmas together, she had been sleeping when she was awakened by him slapping and punching her face. He bit her on her chest and punched her body. Whilst she was on the floor he kicked her and pulled her back onto the bed by her hair. He then hit her with a belt. She also reported that he had been holding a knife. She managed to get out of the bedroom and sought safety with a friend who was also at the address. The friend calmed Mr L down which then

allowed Ms X to leave the address. On leaving the address she reported the assault to the Police. At the time of reporting the assault she also said that he had damaged her IPod in a separate incident that had occurred at his address a few weeks prior to this incident. Mr L was arrested for assault and criminal damage. He appeared in court on 29.12.08 and was bailed until 09.02.09 with conditions that required no direct or indirect contact with Ms X.

3.41. Lambeth Police made a second referral to the Refuge IDVA service about Ms X on 29.12.08 who re-established contact with her that day. Mr L saw his CC1 (unplanned) on the same day. He reported that he had been bailed at court that day following a further argument with Ms X. CC1 obtained details from the CSU. Mr L failed a couple of subsequent planned appointments but was reviewed by the Consultant with CC1 present on 05.01.09, the resulting plan was to continue with medication and regular reviews, liaise with Probation and Police, and set up the Care Programme Approach[7] (CPA) with Probation and family. Mr L attended 3 unpaid work sessions and 3 supervision appointments with Probation between 30.12.08 and 13.01.09.

3.42. On 14.01.09 Mr L called at the LEO offices and his presentation was noted as quite strange and caused concern. A medical review with the SpR was arranged for the next day and attempts were made to contact him to remind him but he did not attend. Concerned at the history and of recent presentation the SpR re-commenced arrangements for a MHA assessment on 16.01.09. However he was told that the South West Sector's Duty Team were unable to accept the assessment referral and that he should "call back on Monday am."

3.43. Lambeth Living received a report on 19.01.09 from a neighbour advising that the tenant at no. 2 was mentally ill and had been shouting and screaming and putting his clothes outside, he believed he needed help. CC1 tried to contact him that day but failed, then again on 20.01.09, which also failed. He contacted OM1 who had seen him that day and he had presented as paranoid, thought disordered and intimidating. She reported that he has presented like this previously, and recognised that his mental state not only fluctuates from appointment to appointment but will fluctuate during an appointment. This appears on the LEO team notes but the Probation record for that visit shows no

[7] The Care Programme Approach (CPA) is the national framework for mental health services assessment, care planning, review, care co-ordination, and service user and carer involvement focused on recovery.

recording. CC1 contacted the CSU for updates and was advised of a MARAC meeting re Ms X on 21.01.09 and invited to attend. He contacted the AMHP team re the MHA Assessment and was advised they were on their way to court and would call back. A discussion with the Consultant Psychiatrist confirmed the need for a MHA assessment as soon as possible given his deteriorating mental state and associated risks, particularly toward Ms X.

3.44. On 21.01.09 the Consultant and CC1 managed to see Mr L. The notes record extreme preoccupation with Ms X and that again she was part of his paranoid delusional system. A section 3 of the MHA was formally initiated and the need identified for the second opinion doctor and AMHP to complete their aspects of the assessment within the next 2-3 days, police assistance was likely to be needed. He refused informal admission or the support of the Home Treatment Team (an intensive support service for people in crisis). The medical notes state that "he is quite paranoid, thought disordered and appears to be experiencing intermittent hallucinations. He is quite labile in mood and behaviour, at time confrontational and agitated. He describes a widespread conspiracy involving his ex-girlfriend and believes that people have been taking shots at him and might come to harm him with knives". When the AMHP team were informed that a first medical recommendation had been completed they responded that there were 9 other assessments, which would cause a delay.

3.45. The MARAC notes of 21.01.09 show a number of actions, but that most, including the protection of the victim, relied upon the MHA Section 3 assessment and its successful application. Unfortunately this did not proceed in a timely way and although there is evidence of some good co-ordination between agencies following the MARAC meeting, the Section 3 assessment remained the main protection tool. SLaM records show the CC1 and the team's Social Worker making efforts to get a MHA assessment completed during 28.01 and 30.01.09. A visit to Mr L's address with the appropriate professionals required to undertake a formal assessment took place on 30.01.09 but Mr L was not at home. The Probation record shows Mr L as having attended for his unpaid work and supervision sessions on 27.01.09 and that he attended court on 29.01.09 re his breach of the community order conditions. For the latter he was

given a Mental Health Treatment Requirement[8] (MHTR) to run alongside his community order. This was relayed to the CC1 on 30.01.09.

3.46. Mr L presented himself at the LEO offices on 03.02.09 and was stressed and tearful, he admitted paranoid thoughts and being frightened of perceived threats towards him. He had an impending court hearing on 09.02.09. He agreed to an informal admission and was hospitalised straight away. The following day a Section 3 MHA assessment commenced due to concerns about the extremely volatile nature of his condition. He was subsequently transferred to the PICU on 16.02.09.

3.47. During Mr L's admission his court hearings were adjourned and the refuge kept in contact with Ms X. The Probation records show his missed appointments as "acceptable" as he was in hospital. On 19.03.09 as Mr L was starting to improve the notes state that an application for a Community Treatment Order (CTO)[9] was commenced by the Consultant Psychiatrist because of the " Very high risk of relapse and needs better safeguards in place (given co-morbid complex needs) with CTO given the serious risks of violence". The CTO application was mentioned again on 09.04.09 but there is no further mention in the records. His discharge planning meeting was held on 20.04 09 and he was discharged the same day with follow up by the LEO team. Neither the Section 3 detention or CTO application are referenced in the SLaM IMR, nor is the legal framework of section 117 aftercare referred to though aftercare was clearly planned.

3.48. Whilst Mr L was in hospital the refuge continued contact with Ms X and the court hearing was severally adjourned. The Probation Service put his IDAP attendance on hold and "re-tiered" him to a T4 in terms of risk because of the high risk of harm to a known adult. Mr L's new care co-ordinator (CC2) with the LEO team contacted OM1 2 weeks after his discharge to inform her of his discharge. A 3 - way meeting was held between Mr L, OM1 and CC2 on 14.05.09, the note states that his "Risk of Harm" is recorded as high and "risk of re-offending" as medium/high. It also states that the victim is known to contact him. He was re-referred for IDAP but postponed for 2 months for additional

[8] Mental Health Treatment Requirements were implemented in 2005 as part of the Criminal Justice Act 2003 and can be attached to Community Orders by Courts during sentencing.

[9] Community Treatment Orders were introduced in November 2008, by new sections 17A-G being inserted into the Mental Health Act 1983 by the Mental Health Act 2007.

preparation work "given no requirement to take medication and can get aggressive". The case was transferred to a new Probation Officer (OM2) on 26.05.09 and on 09.06.09 his court hearing was committed to crown court, Mr L had entered a not guilty plea. He started on the IDAP course mid June and gave conflicting information re any contact with the victim, explaining to the IDAP worker that he was still seeing the victim and that he had had mental health problems at the time of the offence. He was still claiming to OM2 that he was not having contact.

3.49. He continued with his probation supervision and IDAP and the fact that he and Ms X were living together became known to both the Probation workers and LEO team. The Probation WSO informed the refuge worker of this. Living with Ms X was in breach of his bail conditions and though he pleaded guilty at the next court hearing on 21.07.09 the Judge was unhappy with this information and adjourned for a pre-sentence report. His probation risk "tier" was changed by OM2 from T4 to T3 on the 22.07.09, the notes give no reason for this. OM2 registered Mr L as a level 2 MAPPA[10], it is presumed because OM2 thought there would be greater oversight as a consequence though did nothing to make this happen. Some months later the registration was rescinded as Mr L's offences and penalties did not in fact, reach the MAPPA level 2 criteria and registering him as such was an error.

3.50. The Refuge worker assisted Ms X to secure independent accommodation based on the fact that she was homeless and at risk of domestic violence and this enabled her to move out of Mr L's flat. Probation and the LEO team remained in contact monitoring Mr L's condition, he was sporadically attending his unpaid work requirement, missed a couple of supervision sessions and continued with IDAP. The records suggest that contact with the LEO team during the remainder of 2009, was mainly on Mr L's terms, collecting his medication though often late and often not attending for medical reviews, when seen for his medication he was noted as seeming well. The Crown Court hearing was adjourned twice more for psychiatric reports on 30.09.09 and 09.10.09.

[10] Multi Agency Public Protection Arrangements. is the name given to arrangements in England and Wales for the "responsible authorities" tasked with the management of registered sex offenders, violent and other types of sexual offenders, and offenders who pose a serious risk of harm to the public. Level 2 is for all offenders who have received a custodial sentence of 12 months or more in prison for a sexual or violent offence and whilst they remain under Probation supervision.

3.51. In early October Mr L was suspended from his unpaid work due to smoking cannabis, OM2 was informed and the notes are clear she was aware that this can precipitate a rapid relapse in his mental health and notified CC2 at the LEO team and made the Court aware. The outstanding court case was finally concluded on 25.11.09 Mr L was given a suspended sentence order of 18 months, custody was suspended for 24 weeks and an 18 month Mental health Requirement was made. His probation "tier" was moved back up from T3 to T4 the reason given on the record "instructed by SPO" (Senior Probation Officer).

3.52. Probation supervision and IDAP attendance continued uneventfully into the new year, when "victim empathy work" was scheduled to start. Mr L completed his IDAP sessions on 17.02.10 where he was noted to have contributed well. There was no record of his victim empathy work beginning. His probation supervision continued with little to note other than he was in need of purposeful activity. The record states that until this achieved he would need to stay on weekly supervision and if he achieved this, his reporting would be reduced. He failed to go to a work project but the following week's notes state " Needs to stay on fortnightly until finds more positive things to do." Similarly nothing has changed when the notes state 2 weeks later "Can reduce to monthly reporting". and an entry the following day (31.03.10) shows the reasons as: "Finished IDAP, treatment fine, reduced to Tier 3, not seeing victim, apathetic but not a risk."

3.53. 06.04.10 Mr L's psychiatric care was transferred to the South West Recovery and Treatment Team (SWT) and had a new Care Co-ordinator (CC3). During most of 2010 he continued contact, sometimes erratically, with both the SWT and Probation. He gained some employment and then lost it during the summer.

3.54. On 15.09.10 Mr L admitted to OM2 that he had seen and texted Ms X though on 13.10.10 he claimed he had not had contact with the victim. Mr L's original community order expired on 12.10.10.

3.55. On 16.11.10 he attended the SWT base for a medical review. The notes state that his mental state appeared stable and well but he complained that he was sleeping too much and felt he was taking too much of one of his medications. The notes say that he told them his "girlfriend visits every now and then".

3.56.On 07.12.10 CC3 presented Mr L's case at a team review with a view to stepping down his care to a medication clinic or discharging to his GP. It was decided that based on his history of non-compliance and substance misuse, it will be wise to keep him with the medication clinic but get his GP to prescribe his medication while his mental state is being monitored by the medication clinic. A plan was also made to do an unannounced visit to his flat as it was recognised that Mr L kept professionals away from it, also to ascertain if his rent was up to date. There is no note of the latter being established and a home visit did not take place until after OM2 had contacted CC3 on 28.01.11 to express concerns re Mr L's recent presentation. The home visit was attempted on 31.01.11 but access not gained. On 01.02.11 OM2 had written formally to the SWT informing them that Mr L was claiming not to be taking his medication. The Team responded that they would review his mental state but this did not happen and he began evading contact. OM2 contacted CC3 again on 22.02.11 to express further concerns about Mr L's mental state and was told he was due for review the following day. He did not attend.

3.57.Mr L visited the SWT offices to collect medication on 28.02.11 and was noted to be "guarded and slow " and "shabbily dressed", he again expressed concerns about being over medicated. CC3 informed of a plan to undertake a joint home visit with OM2 and that his was a requirement of his community order, if he was not there to let them in he would be in breach of his order. The joint visit took place on 09.03.11, he had a dog on a chain in the kitchen, the flat was reasonably clean with signs of someone staying, which Mr L denied. He wouldn't let them see the fridge to ascertain his eating (he was noted to be looking thin) but didn't display any overt psychotic symptoms. He attended a day early for his medical review on 10.03.11 and agreed to return the following day, which he didn't. He did attend for a blood sample to check his medication levels on 21.03.11 and again on 24.03.11 for his medication. His presentation on that day was thought disordered and he accused the Team of covertly increasing his medication and became angry when this was denied. CC3 tried to get him to see the crisis doctor, which he agreed to. The crisis doctor refused to see him saying " that he should be given an appointment to see his regular doctor instead of just turning up to inform the team that he has stopped taking his medication."

3.58.On 31.03.11 Mr L was taken to St Georges A&E by ambulance escorted by the Police. Neighbours called the Police after noticing a broken window; they found

Mr L on the floor, dishevelled and blood stained. A comprehensive assessment and history was undertaken and recorded by the Home Treatment Team at A&E and Mr L was admitted to a psychiatric triage ward under Section 2 (MHA) his behaviour was volatile and a PICU referral considered but not made. On 02.04.11 he was transferred to another ward. Apart from the nursing and medical observations and many notes about the location and wellbeing of Mr L's dog there is a note on 08.04.11 to say he was visited by "his girlfriend" and again on 10.04.11. Nothing else was noted about discussion with her or possible risks or to identify her. There were also several interchanges with Lambeth Living about the broken window which needed fixing or boarding.

3.59. Ms X picked Mr L up from the ward for a planned day's leave to go to his flat on 12.04.11 to have his door and window fixed. Ms X is referred to as both his "ex-girlfriend" and "girlfriend" in the notes. Nothing is observed re DV history specifically with Ms X and particularly when ill.

3.60. Mr L was discharged on 13.04.11 with follow up provided by the SWT. His final meeting with OM2 was on 18.04.11 when his community order finished. His presentation over the following weeks was very mixed with signs of relapse. He was very focussed on using CC3 to negotiate with Lambeth Living over a variety of housing issues. Repair workers were reported as reluctant to visit due to intimidating behaviour by Mr L.

3.61. On 23.06.11 CC3 visited him at home with a member of the Home Treatment Team to assess his suitability for their intensive intervention due to his signs of relapse. He would not let them in as he said he had a friend there with her baby and agreed to attend the SWT offices that afternoon. Contact with SWT remained focussed on practical difficulties including mention of a £3000 mobile phone debt. His mental state varied considerably as did his medication compliance. He had a job for a while but lost it. In October he responded to looking tired by saying his girlfriend was around and he wasn't getting much sleep. This is not remarked upon in the notes.

3.62. He was assessed for the first time by a new Consultant Psychiatrist on 28.11.11. He was reported to be in a stable mental state, had recently found another job and had recently finished with his girlfriend. He minimised his history of violence

when ill. He remained relatively stable though had difficulties with his benefits due to part time work he was undertaking.

On 25.04.12 Lambeth Police attended a domestic incident at Mr L's flat. He was arrested for assault and threats to kill. His girlfriend (Ms Y) was asleep and was awakened by him shouting that he was going to kill her, punched her in the face and kicked her; she later reported that he had used a knife during the incident that had caused a cut to her finger, he denied the assault. The Police referred Ms Y to the Gaia Centre (by then providing the refuge service) on 26.04.12, and contact was made with her.

3.63. SWT notes suggest they became aware of this arrest on 03.5.12 when an entry was made stating he had been assessed by the Criminal Justice Mental Health Service at West End Central Police station. That assessment is not available to this review but he was given conditional bail so it is assumed he was not in need of urgent hospitalisation. He was arrested again on 01.05.12 when Ms Y reported that he had breached his bail conditions by harassing her, he had sent 4 texts and left voicemail messages. He was charged with harassment and remanded in custody.

3.64. SWT were unaware of his detention in custody and made efforts to locate Mr L concerned he was relapsing and the risk of harm to others was increasing. Contact was made with the police on 22.05.12 to carry out a welfare check. They received a message on 24.05.12 that he was in custody. The team endeavoured to establish which prison he was in and eventually found out he was in HMP Thameside on 28.05.12. Contact was received from Probation on 03.07.12 saying that Mr L was due in court the following day and may be released under Probation supervision. The plan, if released, would be to consider for a depot[11] injection due to non-compliance with medication.

3.65. On 04.07.12 Mr L appeared in court and received a six months prison sentence suspended for 12 months with a restraining order and a requirement to undertake 25 days of 1-1 IDAP for battery.

3.66. Mr L saw CC3 on 05.07.12 said he had been "on holiday at the Thames", stated he had got into trouble as he had got drunk and got into a fight but did not say

[11] Long lasting anti-psychotic medication given by injection.

who with. His notes from that point on refer briefly to his presentation but are almost always dominated by practical issues such as sorting out his benefits, freedom pass etc. until a Consultant Psychiatrist assessment on 03.09.12 when he said he felt stressed & that he might "lose it" & "do something" because no one is helping him. He claimed not to have had his benefits restored since leaving prison and a whole range of other troubles including smashing up his flat. He admitted using cannabis and cocaine over the weekend. His mental state examination however suggested he was more stable than as initially presented.

3.67. Mr L's new probation officer OM3 tried to get grips with Mr L and noted early the links between a deterioration in his mental health and re-offending. She attended a couple of appointments at SWT with him and liaised regularly. She began the 1:1 IDAP sessions on 23.08.12. He disclosed he had met someone who wants to go out with him "Nastasia". OM3 consulted with the WSO for advice about a possible new partner and was advised to try and find out more about her. The IDAP requirements mean partners are contacted by the WSO. OM3 tried to establish more at the next session but he wouldn't give information.

3.68. The deterioration in Mr L through September was noted by OM3 as well as CC3 and his psychiatrist. It was recognised that at that time he had a lot of external social stressors relating mainly to money concerns as he was not receiving any benefits and was in arrears with all sorts of payments including rent.

3.69. On 10.10.12 the Police received a report of a burglary at Mr L's address with no property stolen but an apparent forced entry. The Police believed it was a forced entry to obtain a crime number to get his door repaired.

3.70. On 26.10.12 a referral was accepted by the Single Homelessness Project (SHP) Lambeth tenancy support, due to Mr L's rent arrears and known mental health issues which stated he had a diagnosis of paranoid schizophrenia in 2007. A first contact was made on 08.11.12 and arrangements for a home visit on 14.11.12 though it transpired they had gone to the wrong address. A further appointment was given for 26.11.12.

3.71. On 17.10.12 Mr L was arrested for breach of a court order after being called by a member of the public who had seen him arguing aggressively with a woman on the street. It transpired this was Ms Y and on appearing in court on 19.11.12 his

suspended sentence of 24 weeks was activated. He was seen by a mental health nurse in custody on 17.10.12 who stated he was difficult to engage but there were no overt psychotic symptoms that would warrant diversion to hospital.

3.72. OM3 informed CC3 that the timing of his sentence meant that when he was released in 12 weeks time he would have no order or supervision period left. He was in HMP Belmarsh.

3.73. Mr L was admitted to HMP Belmarsh on 19.11.12 and as part of his admission process his contact with the Mental Health Services was noted, as was his psychiatric medication, which he had with him when admitted. He was not referred at this stage to the prison mental health in-reach team. This took place on 3.12.12 when a prison nurse noted this had not happened whilst reviewing his medication and records. A forensic social worker (FSW) from the team was allocated and made contact with the SWT on 6.12.12, CC3 was not available to speak to him, so he arranged to ring again the following day.

3.74. On 07.12.12 the FSW spoke to CC3 for some mental health history, management advice and to arrange discharge planning. He was asked to email the request to herself and Mr L's Responsible Medical Officer (RMO) which was done the same day. When no information had been received by 10.12.12, the FSW telephoned the SWT but was told CC3 was not available; he left a message asking her to return his call. She did not.

3.75. On 10.12.12 a prescription was prepared in conjunction with Dr F an associate specialist based at Belmarsh and employed by SLaM, which was to be actioned when confirmation was received from CC3 and/or his community RMO.

3.76. On 11.12.12 the FSW contacted SWT to say Mr L was about to be released, he was informed CC3 was not in the office so he left a message to that effect. A pragmatic decision was taken by the Mental Health In-reach Team to issue Mr L with 7 days of his psychiatric medication and this was handed to him on release.

3.77. On 12.12.12 CC3 made phone contact with Mr L, she arranged to see him the following day and the plan was noted as: to meet with him the following day, encourage him to stay for the Christmas meal, arrange a medical review asap and to arrange a joint home visit. He was seen briefly at the SWT offices the

following day but left before CC3 could engage with him. He was described by colleagues as incoherent in his speech and confused about why he was there.

3.78. On 17.12.12 Mr L was briefly reviewed by the team in his absence, who suggested a referral was made to the Home Treatment Team if he failed to attend the SWT that afternoon which he did. A referral was made to HTT but brief information was given that didn't outline the risk of harm he posed when unwell, the referral was declined.

3.79. On the same day the SHP support workers visited Mr L at home and found him in, he seemed to want support but would not give the information needed and every so often would ask again who they were and why they were there. he disclosed he had just come out of prison but not why he was there. A woman was present, who they took to be a girlfriend by their body language and that they seemed excited about Christmas. One of the workers D was concerned about his mental health noting the following behaviour:

-Incongruent mood and speech – laughing at things that were not funny. Becoming very agitated quickly without cause to any concerning subject matter being discussed, changing mood rapidly and to the extremes.

-Thought disorientation: Unable to concentrate for any long period of time. Jumping from old subject matter to new. Difficulty in following conversation at times.

-Paranoia: Mr L said that he was concerned what others thought about him regularly and was very suspicious of staff whilst also stating that he was grateful of help.

-Would not maintain eye contact, and often stared at the wall behind the staff whilst making conversation.

-Mr L asked to read the consent form however, while doing so, he was staring intently at staff when he believed they were not aware of this.

3.80. The Police were called to a domestic incident at Mr L's address on 18.12.12 as neighbours reported sounds of a domestic disturbance. Mr L and Ms Z were

present and "safe and well". They were separated and spoken to in different rooms. They independently confirmed that they had argued about Christmas presents, both were described as "tearful" and wanting to spend Christmas together. Both were given a tear out DV advice slip containing details of the National Domestic Violence Helpline and other related organisations. The officers conducted intelligence checks that recorded that both parties had not been involved in any prior domestic incidents with each other in the last 2 years.

3.81. The routine supervision of the domestic incident report was undertaken by a DI within the Community Safety Unit at Lambeth. The risk assessment was confirmed as standard and a request was made to ensure that a DV information pack was sent to both parties.

3.82. D (worker from SHP) attempted to contact the SWT. She experienced considerable difficulties getting through recorded as follows:

"18.12.12 Phone lines were dead. Tried x 3 D called Lambeth general enquiries number as could not get through to CMHT South. She was given an alternative number to try which was for the older person's team – They were unable to help. D called back general enquiries again and she was given another number. There was no answer and no facility to leave a message, D asked for a manager's mobile number but this was refused.
19.12.12 Phone lines were dead. Tried x 4 D contacted CMHT North by phone and was advised that they have had a few calls regarding CMHT South and there was a problem with the phone lines. D asked if CMHT were able to help her as she had some questions about risk, and gave the clients name. D was advised that they could not help her or give her an alternative number and that she would need to keep trying the CMHT South Team until they answered.

When contact was eventually established with [CC3] on 20.12.12, D reported points 1 – 5 listed above, suspecting that Mr L was unwell. D asked if this was unusual behaviour for him CC3 advised that he could be 'aggressive and vicious' and that staff should not visit him at home alone. She also advised that Mr L has not taken his medication in the past, which could be a risk in the future. CC3 informed D that he had just been released from prison and was convicted of assaulting his partner. DB informed CC3 that there had been a woman present at the flat while she was there.

The SHIP IMR reports that " [CC3] stated that she sees [Mr L] on a fortnightly basis, and does not feel she needs to make an additional appointment based on the information from D.

The above contact and information was not noted in the SWT electronic record.

3.83. On 20.12.2012 Mr L was arrested for shoplifting in Oxford Street, appeared at magistrates court on 21.12.12 and fined £100.

3.84. CC3 having failed to see Mr L since 13.12.12 undertook an accompanied home visit on 24.12.12 to deliver his medication, he was not in/answering and she put a crisis advice leaflet through his letterbox. The SLaM IMR says that medication was put through the letterbox but the chronology categorically states not.

3.85. On 28.12.12. the Police attended Mr L's address as he had reported being assaulted by his girlfriend. On arrival everything was calm. Mr L said that he had argued with his girlfriend, as she had wanted to stay out in London longer than he wanted. He agreed to leave the flat for the evening and left with the Police saying he would stay with friends in Clapham. When reviewed by a DS within the CSU it was identified that a number of standards had not been met. PNC checks on both had not been made and intelligence checks only went back 2 years. The supervising officer attempted to phone both parties on 29.12.12 but received no reply. A request was made to bring the paperwork up to initial reporting standards, which was done, on 29.12.12 and 02.01.13.

3.86. On 06.01.2013 a missing person's report was made by a mutual friend in relation to Ms Z. Police forced entry to Mr L's address at 1.45 am on 07.01.2013 and Ms Z's dead body was found.

3.87. Mr L was arrested for the murder of Ms Z early on 07.01.2013.

4. Analysis

<u>Mr L's Mental Health</u>

4.1.Mr L was known to SLaM from August 2005 when his then diagnosis of "acute manic episode with psychotic features" was already linked to cannabis misuse. He became ill again in the Spring of 2006 and was hospitalised in July 06, during his relapse a clear link with cannabis was again established and thoughts that he was Muslim became an expressed part of his delusions.

4.2.In Spring 07 Mr L relapsed again and displayed a serious amount of violence and aggression having been admitted after assaulting a stranger, presenting issues around the Muslim faith and very clear evidence of his girlfriend being wrapped into his delusional system.

4.3.In September 08 he displayed clear signs of being unwell again e.g. appeared at the LEO offices in Islamic dress and there were 4 call outs to "domestic incidents" within a month that involved Mr L and Ms X. At one, Ms X informed the Police that he had mental health problems and needed help and Mr L was cautioned. Ten days later he was arrested and charged with assault following another incident with Ms X.

4.4.A further domestic incident was recorded in Essex in October and his mental health continued to deteriorate as observed by his Probation Officer and the LEO team, a mental health section was contemplated. Police attended another incident on 25.12.08 and Mr L was arrested for criminal damage. Early in the New Year his mental health was such that he entered hospital, was detained on a Section 3 and had to be transferred to the PICU for management of his behaviour.

4.5.Some of the medical notes from this period make clear links between his illness and risks to Ms X, as do the notes of the Probation Officer. By this stage if not before, professionals should have known that Mr L's mental health deteriorating was associated with non-compliance with medication, (often manifesting itself at the start of a relapse as complaints about being over -medicated) and the use of cannabis, with the risks to Ms X.

<u>Mental Health and Associated Support Services</u>

4.6. The Lambeth Early Onset team when taking responsibility for Mr L's community care and treatment, overall, provided a good and relatively assertive service. Their function is described on the SLaM website as:

"*The Lambeth Early Onset (LEO) Community Team is part of the LEO Service, which includes the Crisis Assessment Team (CAT) and inpatient Unit.*
LEO Community Team supports people, aged 16-35, who are experiencing mental illness for the first time. We provide care for people who live in the London Borough of Lambeth.
We provide emotional and practical support, education about medication, and psychological therapy, to maintain people's health.
We work together with LEO Services to provide the best help and advice in crises, recovery, or hospital."

4.7. The team continued to support him even when he was out of their geographical area for a number of months before returning to Lambeth and beyond a 3rd in-patient admission, to try and offer continuity. They provided appropriate information to the housing support services when the extent of his risk of harm became clear.

4.8. For the purposes of this review however, their weaker aspect was not to maintain a consistent victim focus when assessing and managing risk when he deteriorated. For example when he informed them his girlfriend was studying abroad they noted concern that he may become isolated. They saw her at that point only in terms of what she could offer their patient rather than what threat he may pose to her when she was around. Summaries of his history do not adequately reflect on this and indeed one summary after he had been charged with assault recorded that Mr L is denying any link between his mental illness and the assault and that it "may be explained as an episode of domestic violence". Even without considerable circumstantial evidence to the contrary recorded in earlier notes, there is no consideration or recording of what that might mean for his ongoing support and risk management. Later on in his care, after a further admission and more overt evidence of the risks to Ms X it became clear that the relationship had continued. As his health deteriorated further, risks to Ms X were still not discussed, noted or planned for. Whilst he was rightly a patient first to the Team, he was becoming "lost" as a perpetrator of domestic violence in particular and of violence to the public in general.

4.9. Four weeks later Mr L's symptoms were more florid and his risks to his girlfriend more overt. This did give rise to some consideration of her safety in his management plan, but there is no evidence these were followed through. There is an implication within the plan that because Ms X may have visited Mr L during this period it would make the risk assessment less concerning. This suggests a poor understanding of the dynamics involved in domestic abuse.

4.10. When his mental health had clearly deteriorated further and Mr L was not co-operating, a Section 3 MHA assessment was considered necessary (electronic patient record 14.01.09) and had not been completed some 20 days later when he was admitted informally (03.02.09) and subsequently placed on a S.3 on 10.02.09. He had expressed very paranoid ideas about Ms X and both the LEO team and the Probation Officer recognised the risk to her. The Team and a MARAC meeting that was held were relying on the Mental Health Assessment to protect her. The delay in getting the Mental Health Act Assessment done was unacceptable in terms of practice, but particularly so when the assessment (and presumed detention) was seen to be the main protective element for Ms X and the public in general. A technical debate can be held about why his admission was delayed. These include an apparent lack of understanding about the "proper process" for initiating an assessment, poor communication between the LEO Community Team and the South West Duty Team providing the Approved Mental Health Practitioner (AMHP) Service, poor prioritisation/undue delay by that service. Even with a MARAC meeting being held during this period attended by all the main professionals involved, the key element of the plan to protect Ms X was the protracted attempt to detain Mr L under the Mental Health Act. The author believes that Ms X was likely to have been at very high risk of harm for a number of weeks between September 08 and February 09 and can find little evidence that she was made aware of that level of risk until the MARAC meeting on 21.01.09 which determined that the WSO and IDVA discuss the "emerging risks" to help her protect herself. There was a remarkable absence of alternative risk management planning by the professionals involved with Mr L when formal detention was not happening. It is understood that the AMHP Service was re-organised in April 2010, to centralise the service so that all referrals are prioritised and if there are delays e.g. for police support or Section 12[12] Doctor

[12] A doctor trained and approved to undertake assessments under the Mental Health Act 1983

availability that is communicated with referring staff so the client can be supported during the delay.

4.11. Given a history of non-compliance and risk of serious harm when ill, it is not surprising that the LEO Consultant initiated action for a Community Treatment Order when Mr L began to respond to treatment in March 09 during his compulsory admission. As a plan it made good sense and whilst they were/are still slightly controversial and at that time relatively new, it could have provided a means to stabilise Mr L when living at home. Other than the entry as a plan in his electronic record, there is no further reference to it. It does not appear to have been pursued though no reason is given. This could have been a lost opportunity.

4.12. Despite Mr L having had a "Mental Health Requirement " attached to his Probation Community Order, Mr L had been discharged from hospital for 2 weeks when his Care Co-ordinator informed the Probation Officer that he was in the community. This and the records seen, suggest that although they must have been party to its proposal[13], the LEO team had little understanding of what a "Mental Health Requirement" meant. There is evidence of some communication particularly between OM1 and the Care Co-ordinator but not of a pro-active plan about the strengths and limitations of the requirement and how to use it to best effect. In December 10, after his community care had transferred to the SWT, consideration was given to stepping down Mr L's care to either a medication clinic or GP care. It is not obvious that any consideration was given about how this would impact on the "Mental Health Requirement" or discussions had with OM2. Despite this however, there is one example where the "Requirement" was used positively to enforce a joint visit between CC3 and OM2 in March 11 when Mr L was again deteriorating.

4.13. The in-patient episode in April 11 shows no recognition of the domestic violence issues, and Ms X was seen as useful to take him home on a day's leave to facilitate repairs to his flat. There is no record of a risk assessment in relation to

[13] The Criminal Justice Act 2003 states that:
"A court may not by virtue of this section include a mental health treatment requirement in a relevant order unless the court is satisfied, on the evidence of a registered medical practitioner approved for the purposes of section 12 of the Mental Health Act 1983, that the mental
condition of the offender-
(i) is such as requires and may be susceptible to treatment, but
(ii) is not such as to warrant the making of a hospital order or guardianship order within the meaning of the Act"

that plan or that the ward staff had established how aware Ms X was of the possible risks.

4.14. The references to Mr L's "girlfriend" in the records of the SWT suggest that Mr L as a perpetrator of domestic violence, receded even further as did his level of risk when unwell. Early signs of relapse were not responded to assertively and Mr L tended to dictate the terms of his contact. The SLaM IMR recognises the lack of regular and/or effective risk assessment and management and that the team was content to assist with his (genuine) practical and financial concerns. The records show a "brief risk screen" in December 11 and whist 3 of the five risks noted were of violence to others no full risk assessment was ever undertaken whist Mr L was a client of the SWT. As well as contrary to Trust policy this must be considered unacceptably poor practice.

4.15. Although there were known risks between Mr L's deterioration and his drug use the SWT did not assertively address his misuse with him. They did no drug screening and didn't utilise the specialist worker attached to the team. As with other areas of his life, Mr L was allowed to deflect any attempts to address this.

4.16. The period of imprisonment immediately prior to the homicide and events after his discharge are of particular concern. Unfortunately despite a recognition of his known mental illness on Mr L's admission to HMP Belmarsh on 19.11.12, he was not referred to the Mental Health In-reach Service provided by Care UK until 03.12.12. The FSW made contact with the SWT on 06.12.12 and left a message for CC3. He rang again the following day seeking information, was able to speak to CC3 and followed up with an email the same day, formally requesting the information. None was received and so this was followed up by the FSW again on the 10th but CC3 was unavailable and a message left requesting contact. A further message was left for CC3 on 11.12.12 in the absence of direct contact, informing her of Mr L's release that day. Other than a copy of the email from the FSW placed in the electronic patient notes there is no record of the attempts to liaise. It is unfortunate that it took 2 weeks of imprisonment before Mr L was referred to the Mental Health In-reach Team. It is even more unfortunate that the SWT did not use the opportunity when it did present, to engage in a proper post release planning, given the history and risks Mr L presented and his lack of compliance with treatment, which were well known.

4.17.A rudimentary understanding of addiction would suggest that Mr L would be likely to seek cannabis and possibly alcohol in some quantity on his release. The lack of urgency and a clear plan to re-engage Mr L at that time is very concerning in terms of practice. That it continued until his subsequent arrest for alleged homicide is worse.

4.18.The difficulties experienced by the Single Homeless Project (SHP) in contacting the SWT between 18.12.12 and 20.12.12 were organisationally unacceptable. Communication lines fail, that no backup plan was in place, or others in the wider organisation able/willing to assist, is of concern. If a fellow professional could not get through what were the chances of a relative/carer/client in crisis? Anecdotally the SHP team members suggested this was not an unusual occurrence.

4.19.The SHP worker (D) when finally getting through to the team added to the picture of concern re Mr L's mental state, given that D had seen him on the 17.12.12 and CC3 had not seen him since October, it is surprising that CC3 didn't feel the need to see him urgently. It is also noteworthy that the SHP worker informed CC3 that a woman was present at the flat and even though she had explained to D during the conversation that Mr L had just left prison for assaulting his partner, this does not appear to have added to CC3's sense of urgency. It is also of concern that this information was not placed on the client record until 28.12.12.

<u>Other issues relating to Mental Health Services</u>

4.20.The issue of some agencies shutting down or going into emergency only mode cannot be ignored. There is a clear sense that Mr L's SWT follow up after leaving prison was influenced by the impending Christmas break in terms of time and attention. When the Home Treatment Team would not take responsibility to follow up Mr L there was no realistic alternative plan.

4.21.A single but concerning event took place when CC3 undertook a home visit and a woman with a baby was present in the house. Given Mr L's history this should have raised child protection concerns and an alert raised.

4.22.As identified in the SLaM IMR, implementation of the Care Programme Approach (CPA) was, particularly by the SWT, weak and not in accordance with

Trust Policy or NICE guidelines. Additionally, Mr L had been detained under Section 3 MHA 1983; this in turn would have entitled him to Section 117 aftercare.[14] Neither the records informing the chronology for this review or the IMR, refer to S117 when undertaking discharge or care planning, but neither has there been a formal S117 discharge meeting (which given his lack of recovery would have anyway have been questionable). It could be argued that the lack of holistic care planning and implementation particularly from April 2010 was a breach of Mr L's entitlement.

Probation

4.23. The early work by OM1 was structured and reasoned, early action was taken to assert the Community Order when Mr L was not co-operating and he was "breached". The intention to breach was discussed with Mr L at a meeting with him prior to sending the formal notification. OM1 did then follow up concerns about the victim because of Mr L's mental ill health and the anger against Ms X that he had displayed, both with the CC1 and Police MARAC liaison officer. OM1 used the opportunity of a return to court to have a "Mental Health Treatment Requirement" added. These had been available since 2005 but their use had been very limited at the point OM1 made the application[15] and this could therefore be seen as at the forefront of practice. It is clear however that both OM1 and the LEO team were unsure of how to use it to best effect. Overall the initial Probation plan was adhered to though the Probation Trust IMR acknowledges a significant amount of inadequate recording. Other than the contact with the Police CSU in late November 2008 there is no evidence of the monthly checks with the CSU that were included in the plan.

4.24. OM1 kept a clear victim perspective and liaising sometimes pro-actively, when concerns were presented. After transfer to OM2 victim issues remained an

[14] 1)This section applies to persons who are detained under section 3 above, or admitted to a hospital in pursuance of a hospital order made under section 37 above, or transferred to a hospital in pursuance of a hospital direction made under section 45A above or a transfer direction made under section 47 or 48 above, and then cease to be detained and (whether or not immediately after so ceasing) leave hospital.
(2)It shall be the duty of the Primary Care Trust or Local Health Board and of the local social services authority to provide, in co-operation with relevant voluntary agencies, after-care services for any person to whom this section applies until such time as the Primary Care Trust or Local Health Board and the local social services authority are satisfied that the person concerned is no longer in need of such services ; but they shall not be so satisfied in the case of a community patient while he remains such a patient.

[15] The Community Order and the Mental Health Treatment Requirement, Seymour & Rutherford 2008 The Sainsbury Centre for Mental Health.

appropriate focus in the beginning, though risk assessments and clear structure to the work were less apparent. Mr L's Probation "tiering" changed a couple of times from tier 4 to tier 3 with no clear rationale. On one occasion the reason given was that he wasn't seeing the victim so was therefore "not a risk", which seems rather optimistic and relies on him being honest about contact which must be considered a risky approach in circumstances of Domestic Violence. They were also changed back to tier 4 twice with the reason given as the Senior Probation Officer decision. This suggests the management supervision process was working but questions the practice of the Offender Manager. A further Mental Health Requirement was attached to Mr L's second Community Order (also for domestic violence), this could again be seen as good practice but again was not used to best effect.

4.25. OM3 also had a victim focus, and tried to establish good links with the mental health team attending a couple of appointments with Mr L. This suggests she was trying to utilise the MHTR. There is a question about whether OM3 should have breached Mr L for failing to give details about his potential new partner "Nastasia" in August 2012. IDAP requires the Probation WSO to make contact with new partners. The author is informed that technically it is possible to breach an offender in these circumstances but that experience suggests the Courts do not favour such applications and that has become a deterrent. Had this occurred there might have been an opportunity to intervene positively in this emerging relationship, but at this stage this is speculative.

4.26. OM3 had less contact time with Mr L due to his imprisonment and the Community Order running out on his release. It may have been helpful if she had made CC3 aware of the 6 month "duty of care" that follows the order expiry, when some help and advice can be sought, however there is little to suggest it would have been used if know.

Essex Police

4.27. There were 3 interventions related to domestic violence by the Essex police. The first in March 2006 appears to have been dealt with within the then current procedures.

4.28. The second in December 2006 was not dealt with adequately even within the prevailing procedures. The crime was recorded as common assault by a stranger, so Mr L's name was not placed on the record and it is not clear that a risk assessment was undertaken. The informant suggests that this incident took place prior to increased scrutiny and oversight, which was implemented in July 2007.

4.29. The offence in October 2008 was not dealt with in accordance with policy. Mr L was cautioned for a serious assault even though he had been cautioned by the Metropolitan Police approximately 6 weeks earlier and had been convicted for battery a month earlier. The informant suggests that at the time, the officers issuing the caution were probably unaware of these 2 most recent incidents, as at the time entries onto the PNC were not always completed in a timely manner. The author has checked and it has been confirmed that these entries did exist at the time of this offence. This suggests that either the attending officers did not check the PNC or gave a caution in spite of this information. Either action is unacceptable practice.

4.30. The DHR Panel is aware of the significant attention that has been paid to improving its response to domestic abuse since 2011 following four domestic homicides that took place between 2008 and 2011. Three of these have been investigated by the Independent Police Complaints Commission and their reports were published in 2012 into the deaths of Christine and Shania Chambers and Jeanette Goodwin and in May 2013 into the death of Maria Stubbings (this followed a re-investigation after concerns expressed by her family into the initial investigation).

4.31. An inspection by Her Majesty's Inspectorate of Constabulary has also taken place and published in May 2013. It's conclusions includes the following statement:

"In conclusion, while Essex Police has made some important changes to improve the way in which it deals with domestic abuse, more still needs to be done to ensure that the risks to victims are adequately managed. HMIC will continue to monitor the force's progress as it works to achieve this vital outcome".

Metropolitan Police

4.32.The Metropolitan Police had 11 interventions for domestic violence with Mr L relating to 3 different women between September 2007 and December 2012.

4.33.The most frequent were against Ms X and the Police reports show that they acted appropriately and within the contemporary procedures, this included appropriate referrals to MARAC and to Refuge. The occasion in September 08 when Ms X didn't want a serious assault taken further because she believed Mr L needed mental health treatment was not pursued at that time. In current practice this would have triggered referrals to Adult Social Care and SLaM.

4.34.Mr L was interviewed with an appropriate adult present when being charged with offences after his mental health issues became clear.

4.35.The offences against Ms Y were dealt with swiftly and on both occasions resulted in Court action. The Police record also shows the investigating officer to have referred Ms Y to MARAC though there is no record of that being received. Further enquiry has revealed that the notification remained in a general police email address and was not referred on to the MARAC Co-ordinator.

4.36.The Metropolitan Police attended Mr L's address twice in relation to Ms Z the homicide victim. Both of these call outs took place in December 2012 and the second was the day before Ms Z is thought to have been killed. An assessment was made on the first visit using the current DASH assessment model and was rated as "standard", the parties were seen separately and the tear out DV information advice slip was given to each. The Police IMR suggests that with the information available that was an accurate rating. The report was supervised by a DI and following the sending of the DV "pack" containing information about local resources for anyone experiencing gender based violence, to each party which was in accordance with agreed local DV practice.

4.37.On the second call out the couple were not seen separately and that is contrary to accepted practice, there was no record of a PNC check on either party and the CRIS report did not record the risk assessment. Intelligence checks were only undertaken for the previous 2 years not the expected 5 years. There is no

evidence that the risk assessment was reviewed in the light of wider information being added.

4.38. On both occasions the assessments focussed on Mr L and Ms Z as a couple for which there was no previous record. An intelligence check on the address would have revealed the fairly extensive history for Mr L with previous partners. An address search would also help to eliminate issues being missed because of an incorrect name spelling or false identity being given.

MARAC

4.39. In common with many agencies the MARAC systems and processes were/are focussed on tracking repeat victims and not serial perpetrators. The "lost" MARAC referral from the Police about Ms Y may have brought Mr L to their attention as such, but possibly without the tools to deal with it.

4.40. Although there is an information sharing protocol, the constituent members of MARAC do not appear to have clarity on what information can and should be shared. This is evident when the concerns about the assessed risk of harm presented by Mr L when ill are shared by SLaM with Lambeth Housing Needs Service but there is no evidence it was shared on as appropriate with Lambeth Living and Housing Support Service providers. This was confirmed at early DHR Panel meetings.

5. Conclusions

5.1. In relation to Mr L's final victim it is difficult to conclude that her death could have been avoided. Her time in the country and with Mr L was very short and it is extremely unlikely she knew the extent of his domestic violence history or the severity of his mental illness. There were only a very few indications to agencies that Ms Z was present in the flat.

5.2. It is clear from this case that if a tragedy such as this untimely death of a 23 year old woman who had only been in the country 3 weeks is to be avoided in the future, greater emphasis needs to be placed on tracking and managing information on serial abusers. It then needs to better inform protective and

possibly discretionary decisions about sharing information with potential victims. It is understood that the Metropolitan Police Service is about to introduce a programme to target DV perpetrators, known as Operation Dauntless, which is to be welcomed.

5.3. There appears to be a clear (at least circumstantial) link between Mr L's mental health and his propensity to violence. If Mr L's mental health had been better and more assertively managed in the 2 years before Ms Z's death it is reasonable to assume that the risks he posed when unwell would have been less. Had the South West CMHT acted with urgency and purpose on Mr L's release from prison they may have been able to make a positive impact on his mental health and/or assessed his need for possible compulsory treatment which previous ill health episodes had required. Mr L's mental health needed assertive care management but in the last 2 years at least, he did not receive it.

5.4. If the Police officers who attended on the 18th & 28th Dec had had full information on the extent of Mr L's DV history and some of the mental health concerns, they may have intervened more assertively, however without the power to disclose that knowledge to Ms Z, it is unlikely to have altered the sad course of events.

6. Good Practice

6.1. The Police appealed the CPS decision not to prosecute following Mr L being charged with assault and criminal damage in September 2008.

6.2. The LEO Service followed up and supported Mr L well beyond their stated remit as an early onset team, both in timescale and geography during 2007/8. This was to provide continuity whilst he was in temporary accommodation and hadn't registered with a GP.

6.3. Although ultimately not used to best effect, the Probation Trust applying for Mental Health Treatment Requirement attachments to 2 of Mr L's community orders was good practice in seeking to use a newly introduced statutory tool.

6.4. The SHP worker made a very determined and persistent effort to share her well assessed and documented concerns re Mr L's mental health and the presence of

a woman at his home with the responsible professional Care - Co-ordinator in mid - December 2012.

7. Recommendations

Individual agency recommendations from IMRs

7.1.***South London& Maudsley NHS Foundation Trust***: - since the death of Ms Z SLaM have undertaken a Serious Incident Review, which formed the basis of their IMR. The Serious Incident Review has been presented to the Trust Board and its recommendations supersede those contained within their IMR and are included in full below:

Psychosis Community Service (Lambeth South)

The panel acknowledged that the investigation had highlighted serious concerns in relation to the Psychosis Community Service (Lambeth South). The panel heard that there were a number of serious issues, which had a significant effect on the delivery of the service.

The panel acknowledged reports, from service management team, that work was underway within the Psychosis CAG to improve ways of working within the North and South teams. It was however reported that more focus had been placed on the Lambeth North team.

The panel agreed that immediate action was required to improve service delivery in the Lambeth South team and recommend, due to the severity of the issues raised, that the Psychosis Community Service (Lambeth South) be placed on special measures. It was the view of the panel that this should be led by the Deputy Director of Clinical Delivery – Community, in order to:

Benchmark the quality of care and undertake a review of the patient profile (auditing a sample of cases).

Review skill mix & staff training

Review staff competencies

Review management and leadership

Audit risk assessments and care plans

Review caseloads

The panel recognised the impact that placing the team on special measures could have on staff. They therefore concurred with the service management's view that members of the senior management team be present (to provide support) when the amended report is fed back to the team.

Board assurance

This panel considered and discussed the board level processes that were in place, which provided assurance on the monitoring of teams/service delivery. The panel agreed that Board oversight was required to monitor the progress of any service where significant concerns (or patient safety issues) had been raised and/or where assurance was required on improvements to service delivery. It was therefore suggested that one way this could be achieved was via board to ward meetings. The panel were of the view that an additional recommendation should be made, from the Board Level Inquiry panel, to propose that the new Chief Executive review the peer review mechanisms that were in place for such cases.

Impact of organisational change

The panel noted that the investigation report had highlighted that the team had been under a lot of pressure, due to organisational change and increased workloads. The panel were concerned to learn that organisation change had impacted upon service delivery and noted that there had been other incidents which had also identified organisational change as a contributory factor.

The panel were therefore of the view that mechanisms should be in place to enable areas of concern, which arose as a result of organisational change, to be addressed. As such, the panel propose that, where organisational change is planned, senior staff within CAGs or corporate services should ensure that monitoring systems are in place to mitigate any impact to service delivery and also respond to any issues that arise. The panel were of the view that an additional recommendation should be included to the report to reflect this point.

SI Report Content

The panel wished to commend the investigation team on the structured investigation that was undertaken and also on the quality of final report.

Recommendations

Recommendation 1

'The Trust to commission a piece of work to address interfaces between services within AMH and between AMH and non-AMH CAG services.'

The panel endorsed recommendation one.

Recommendation 2

'All Trust community teams to meet with the SLAM Forensic Service to learn and develop a protocol for management when patients are discharged from prison.'

The panel endorsed recommendation two.

Recommendation 3

'The Psychosis Community Service (Lambeth South) team manager and team consultant to work together to ensure mandatory training in the team is completed and up to date. This will include the following and should be audited to ensure learning is embedded:

-their responsibilities in relation to safeguarding children and adults

-risk assessment and escalation of concerns for complex patient with a history of violence, drug and alcohol use and psychosis.

-Clinical documentation, including ePJs, meeting minutes, correspondence between slam teams and external agencies.'

The panel endorsed recommendation three.

Recommendation 4

'The Psychosis CAG senior manager team to take up the following areas across the CAG in relation to AMH model work. This will include:

Mental health assessments including history, mental state examinations, formulation and resulting care plans

Drug and alcohol and the use of questionnaires available on ePJs, urinary drug screens, hepatitis B & C and HIV status.

Commissioning SLaM partners to work with the Psychosis Community Service (Lambeth South) team to facilitate team members to work together and develop a vision for the service.

Adherence to NICE Guidelines 120: Psychosis with co-existing substance misuse, March 2011. This includes the provision of the Care Programme Approach to deliver care.'

The panel endorsed recommendation four.

The DHR makes the following additional recommendations for SLaM:

DHR Recommendation 1 The Trust audits its clinical staff to establish the understanding of the extent, impact and risk of Domestic Violence and addresses the findings accordingly.

DHR Recommendation 2 The Trust reviews its physical communication systems at Community Team bases and puts in place contingency arrangements in case of failure.

DHR Recommendation 3 The Trust works with the London Probation Trust to develop a working protocol for putting in place and managing Community Order "Mental Health Requirements".

7.2.***Housing Needs Service:*** The following recommendations appear in their IMR

Recommendations for action/improvement:-

All staff to be reminded of the importance of making detailed case notes without abbreviations.

Team managers to ensure monthly case audits evaluates the quality of case notes.

7.3.***Single Homelessness Project:*** The IMR makes the following recommendations:

-SHP to review the priority and allocations system within the Lambeth Tenancy Support Team

-Review how issues/concerns or incidents concerning client risk are escalated to management level within SHP

7.4.***The Metropolitan Police Service:*** The IMR makes the following recommendations:

Recommendation 1 Lambeth BOCU

It is recommended that the MPS/Lambeth complete intelligence checks on an address at which a DV incident has taken place in addition to any individual checks undertaken on the individuals involved in the incident**.**

Recommendation 2 Lambeth BOCU

It is recommended that Lambeth BOCU officers are reminded to complete intelligence checks in relation to all Domestic Violence and recorded within the Crime Recording Information System (CRIS). This should include mandatory searches of databases including CRIS, PNC and CRIMINT ensuring that relevant information is recorded within the report.

The DHR makes the following additional recommendation for the Metropolitan Police Service:

DHR Recommendation 4

The Metropolitan Police Service gives consideration as to how, within the existing legal frameworks, relevant Police Officers be given discretionary powers to disclose previous acts of Domestic Violence where potential victims are thought to be at risk.

7.5.***Essex Police Service:*** **The DHR makes the following recommendation:**

DHR Recommendation 5

A copy of this report to be sent to the Chief Constable of Essex and Her Majesty's Inspectorate of Constabulary drawing attention to the shortcomings identified in the Essex Police responses contained in it, to ensure they are covered by the improvements already made or planned in Essex.

7.6.***The London Probation Trust:*** The IMR makes the following recommendations:

Recommendation 1 It is recommended that the Assistant Chief Officer for Lambeth should be satisfied that tiering decisions across the borough are soundly based.

Recommendation 2 It is recommended that London Probation and Community Mental Health in Lambeth explore how they might work more closely together to promote the effective management and treatment of offenders with offending related mental health issues. Mr L would be an interesting case example for joint study.

Recommendation 3 It is recommended that London Probation explores whether the role of the WSO could be developed to make them more involved in decision making in the management of orders with an IDAP requirement.

Recommendation 4It is recommended that London Probation consider how it can refresh practitioners' understanding of the role of MARAC so that maximum use is made of this resource

The DHR makes the following additional recommendation to be read in conjunction with 7.2 recommendation 3 and the internal Probation Trust 2nd bullet point (above):

DHR Recommendation 6

The London Probation Trust and SLaM work together to develop a working protocol for putting in place and managing Community Order "Mental Health Requirements".

7.7.***Refuge*** The IMR makes the following recommendation:

Recommendation 1 Refuge to record perpetrators' names on REMIT. Refuge has already implemented this change, in December 2012.

7.8.***MARAC*** The **DHR makes the following recommendation:**

DHR Recommendation 7 Consideration be given to reviewing the operating protocol to improve the tracking and management of serial offenders. e.g. Item 10 - Referral Criteria point 3 - Potential Escalation should this refer to number of call outs to a victim and/or an alleged perpetrator?

7.9.**Safer Lambeth Partnership: The DHR makes the following recommendation:**

DHR Recommendation 8

Safer Lambeth Chair to forward a copy of this DHR to the Chair and Chief Executive of South London & the Maudsley NHS Foundation Trust for the information of their Board. The Board to consider any further actions required to augment the internal review already presented to them and any necessary additions to their current action plan.

DHR Recommendation 9 Review the information sharing protocol to ensure it is still relevant, all necessary parties are signed up and understand its operational implications and audit how well it is disseminated across those agencies' staff.

DHR Recommendation 10 The Safer Lambeth Partnership monitors and reviews progress against the Action Plan.

DHR001 Action plan:

Rec. No	Agency	Recommendation	Timescale for completion
1	**South London & Maudesley NHS Foundation Trust**		
1.1	South London & Maudesley NHS Foundation Trust	The Trust to commission a piece of work to address interfaces between services with AMH and between AMH and non-AMH CAG services.	March 2014
1.2	South London & Maudesley NHS Foundation Trust	All Trust community teams to meet with the SLAM Forensic Service to learn and develop a protocol for management when patients are discharged from prison.	April 2014
1.3	South London & Maudesley NHS Foundation Trust	The Psychosis Community Service (Lambeth South) team manager and team consultant to work together to ensure mandatory training in the team is completed and up to date. This will include the following and should be audited to ensure learning is embedded: - Their responsibilities in relation to safeguarding children and adult - Risk assessment and escalation of concerns for complex patient with a history of violence, drug and alcohol use and psychosis - Clinical documentation, including ePJs, meeting minutes, correspondence between clam teams and external agencies	February 2014
1.4	South London & Maudesley NHS Foundation Trust	The Psychosis CAG senior manager team to take up the following areas across the CAG in relation to	April 2014

		AMH model work. This will include: - Mental health assessments including history, mental state examinations, formulation and resulting care plan - Drug and alcohol and the use of questionnaires available on ePJs, urinary drug screens, hepatitis B & C and HIV status. - Commissioning SLAM partners to work with the Psychosis Community Service (Lambeth South) team to facilitate team members to work together and develop a vision for the service. - Adherence to NICE Guidelines 120: Psychosis with co-existing substance misuse, March 2011. This includes the provision of the Care Programme Approach to deliver care.	
1.5	South London & Maudesley NHS Foundation Trust	The Trust audits its clinical staff to establish the understanding of the extent, impact and risk of Domestic Violence and addresses the findings accordingly.	September 2014
1.6	South London & Maudesley NHS Foundation Trust	The Trust reviews its physical communication systems at Community Team bases and puts in place contingency arrangements in case of failure.	April 2014
1.7	South London & Maudesley NHS Foundation Trust	The Trust works with the London Probation Trust to develop a working protocol for putting in place and managing Community Order “Mental Health Requirements”.	July 2014

2	**London Borough of Lambeth-Housing**		
2.1	London Borough of Lambeth-Housing	All staff to be reminded of the importance of making detailed case notes without abbreviations.	Completed.
2.2	London Borough of Lambeth-Housing	Team managers to ensure monthly case audits evaluates the quality of case notes.	Completed.
3	**Single Homelessness Project (SHP)**		
3.1	Single Homelessness Project (SHP)	SHP to review the priority and allocations system within the Lambeth Tenancy Support Team.	Completed.
3.2	Single Homelessness Project (SHP)	Review how issues/concerns or incidents concerning client risk are escalated to management level within SHP.	Completed.
4	**The Metropolitan Police Service – Lambeth BOCU**		
4.1	The Metropolitan Police Service – Lambeth BOCU	It is recommended that the MPS/Lambeth complete intelligence checks on an address at which a DV incident has taken place in addition to any individual checks undertaken on the individuals involved in the incident.	Completed.
4.2	The Metropolitan Police Service – Lambeth BOCU	It is recommended that Lambeth BOCU officers are reminded to complete intelligence checks in relations to all Domestic Violence and recorded within the	Completed.

		Crime Recording Information System (CRIS). This should include mandatory searches of databases including CRIS, PNC and CRIMINT ensuring that relevant information is recorded within the report.	
4.3	**T**he Metropolitan Police Service – Lambeth BOCU	The Metropolitan Police Service gives consideration as to how, within the existing legal frameworks, relevant Police Officers be given discretionary powers to disclose previous acts of Domestic Violence where potential victims are thought to be at risk.	Completed.
5	**Essex Police Service**		
5.1	Essex Police Service	A copy of this report to be sent to the Chief Constable of Essex and Her Majesty's Inspectorate of Constabulary drawing attention to the shortcomings identified in the Essex Police responses contained in it, to ensure they are covered by the improvements already made or planned in Essex.	To be completed once review has finished.
6	**London Probation Trust**		
6.1	London Probation Trust	It is recommended that the Assistant Chief Officer for Lambeth should be satisfied that tiering decisions across the borough are soundly based.	Completed.
6.2	London Probation Trust	It is recommended that London Probation and Community Mental Health in Lambeth explore how they might work more closely together to promote the effective management and treatment of offenders with offending related mental health	Completed.

		issues. Mr L would be an interesting case example for joint study.	
6.3	London Probation Trust	It is recommended that London Probation explores whether the role of the WSO could be developed to make them more involved in decision making in the management of orders with an IDAP requirement.	April 2014
6.4	London Probation Trust	It is recommended that London Probation consider how it can refresh practitioners' understanding of the role of MARAC so that maximum use is made of this resource.	Completed .
6.5	London Probation Trust and SLaM	The London Probation Trust and SLaM work together to develop a working protocol for putting in place and managing Community Order "Mental Health Requirements"	April 2014
7	**Refuge**		
7.1	Refuge	Refuge to record perpetrators' names on REMIT. NB Refuge has already implemented this change, in December 2012.	Completed
8	**Lambeth MARAC Steering Group**		
8.1	Lambeth MARAC Steering Group	Consideration to be given to reviewing the operating protocol to improve the tracking and management of serial offenders e.g. Item 10 – Referral Criteria point 3 – Potential Escalation should this refer to number of call outs to a victim and/or an alleged perpetrator	November 2014
9	**Safer Lambeth Partnership**		
9.1	Safer Lambeth Partnership	Safer Lambeth Chair to forward a copy of this DHR to the Chair and Chief Executive of South London & the Maudsley NHS Foundation Trust for the	To be completed once review has been published.

		information of their Board. The Board to consider any further actions required to augment the internal review already presented to them and any necessary additions to their current action plan.	
9.2	Safer Lambeth Partnership	Review the information sharing protocol to ensure it is still relevant, all necessary parties are signed up and understand its operational implications and audit how well it is disseminated across those agencies' staff.	To be completed once review has been published.
9.3	Safer Lambeth Partnership	The Safer Lambeth Partnership monitors and reviews progress against the Action Plan	Ongoing

Appendix 1
Terms of Reference

SAFER LAMBETH PARTNERSHIP

DOMESTIC HOMICIDE REVIEW (DHR) 001

TERMS OF REFERENCE

Subject: Ms Z **dob** Retracted

Perpetrator: Mr L **dob** Retracted

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1. DHR Criteria

On initial inspection this case fits the DHR criteria .

On 4 February 2013, in line with the DHR guidelines, Lambeth Police formally notified Derrick Anderson and Chief Superintendent Bell that the murder of Ms Z was domestic violence related.

On 14 February Jo Cleary, in her role as Chair of the Adult's Safeguarding Board, after having reviewed the DHR criteria made a recommendation to Derrick Anderson and Chief Superintendent Bell that Lambeth should commission a DHR.

On 20 February Derrick Anderson and Chief Superintendent Bell formally wrote to the Home Office to advise that, after having reviewed the Home Office DHR criteria, Safer Lambeth have made the decision to commission a domestic violence homicide review surrounding the murder of Ms Z.

The death meets the Domestic Homicide Review criteria as follows :

Domestic homicide review means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by

(*a) a person to whom he was related or with whom he was or had been in an intimate personal relationship*,

2. Panel Membership

The Safer Lambeth Domestic Homicide Review Panel will comprise:-

- Metropolitan Police

- London Borough of Lambeth
- Lambeth Clinical Commissioning Group (CCG)
- South London & Maudsley Hospital (SLaM)
- Refuge-who run the Gaia Centre
- London Probation Trust
- Lambeth Living

Members' responsibilities will be:-

- To agree the Terms of Reference.
- To attend as many panel meetings as possible. Agencies will be expected to nominate a deputy of appropriate seniority to attend in their absence where possible.
- To ensure Information Management Reviews are completed within their own organisation in the time frame agreed by the Panel.
- Ensure that the IMRs are of a sufficient standard and are written in line with the guidance.
- Ensure that the overview report is of a high standard and is written in line with the guidance.

3. Independent Management Reviews (IMRs)

IMRs have been requested from:

- SLaM
- Metropolitan Police Service
- Lambeth CCG
- London Probation Trust
- Lambeth Living
- Job Centre Plus
- Refuge-who run the Gaia
- Belmarsh Prison
- SHP
- Lambeth Council-Housing Options service

Each IMR should provide:-

- Detailed factual report of agency involvement

- Analysis of involvement
  The report writer is expected to rigorously analyse the involvement of their agency. Consider the events that occurred, the decisions made, and the actions taken or not. Where judgements were made, or actions taken, which indicate that practice or management could be improved, try to get an understanding not only of what happened, but why.

- Effective practice and lessons learnt
  E.g. Is there good practice to highlight, as well as ways in which practice can be improved? Are there implications for ways of working? Implications for management and/or supervision, training, working in partnership with others?

- Recommendations for action/improvement

Recommendations should be SMART – specific measurable, achievable relevant and timely. Views on how these could be achieved should be included. Consideration should be given to the resources required to implementing the recommendations such as cost.
Recommendations should be divided into:
Reminders of Best Practice – practice that should already be happening (if this has been a previous recommendation include an analysis of why previous actions have failed)
New – actions that need to be introduced and implemented.

The period under review is from January 1st 2003 or the first point of contact by each agency after that date until 09/01/2013.

IMR authors are asked to pay particular attention to the 2008-9 period of FL's offending activity, subsequent two court appearances and the specific court orders/outcomes and whether agencies acted upon them.

4. Time Parameters for Review

The review is expected to be submitted to the Home Office within 6 months of notification. The DHR Panel had its first meeting on 31 May 2013 therefore the expected timescale will not be met. The Home Office have been advised of this.

Each agency to submit a chronology and IMR by 16/08/2013.

A combined meeting of the Panel and IMR authors to be held 5/9/2013.

If further information is required following that meeting it should be provided by 20/9/2013. Assuming previous timescales are met a further DHR panel meeting to consider the first draft of the Overview Report will be held w/c 14/10/2013 and a final draft for approval provided by 31/10/2013.

5. Structure of IMR

5.1 Introduction (ToR, brief summary, identification of persons subject to review, date of birth, date of death), name and job title of IMR author and confirmation of independence from line management of the case.

5.2 Family tree or genogram if relevant (Including name, date of birth, relationship, ethnicity and address.

5.3 ToR given to IMR author and methodology used to complete the IMR will include:

- Details of parallel reviews/Processes
- Chronology of agency involvement
- Analysis of involvement

- Effective practice and lessons learnt
- Recommendations

6. Involvement of Family Members

Retracted

7. Involvement of other processes, who is leading within what time parameters.

On-going criminal investigation - The case management hearing is set for 27.09.13 with the trial date set for 18.11.13. MPS will keep the panel informed of changes or progress and best practice will be maintained in relation to disclosure issues.

On-going Coroner's investigation - No inquest date has yet been set, the Coroner has been informed of the DHR and LB Lambeth will update as necessary.

8. **Overview Report**

8.1 The Independent Chair of the DHR panel will be the Overview Author.

8.2 The Independent Overview Author will be required to:

8.2.1 Provide a genogram of the family.

8.2.2 Produce a Domestic Homicide Review Overview Report in accordance with the structure and format proposed within paragraphs 8.10 & 8.11 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews.

8.2.3 Summarise the facts of the case bringing together the findings from all the individual IMRs, reviews or enquiries.

8.2.4 Provide critical analysis of the facts and provide an evidence based explanation for how and why events occurred and actions or decisions by agencies were or were not taken.

8.2.5 Specifically address the key issues identified in this case and analyse professional practice accordingly.

8.2.6 Using the benefit of hindsight and evidence from research and previous reviews, judge whether different actions or decisions by agencies may have led to alternative outcomes.

8.2.7 Develop specific lessons to be learned nationally and locally supported by specific and achievable recommendations for improving practice in a timely manner. It will also be important to identify what actions had already been taken by agencies to address lessons learned from the case prior to completion of the DHR.

8.2.8 Prepare an Executive Summary which should include succinct information about the review process, practice issues and lessons learned from the case, and recommendations made.

9. Legal Advice

None taken at this time.

10. Expert Opinion

Depending on information provided in the IMRs, independent clinical (mental health) advice to the chair/overview author may be sought.

11. Media and Communications

No internal communications or external communications will be published until after the criminal proceedings as a minimum. Updates will be provided to the Safer Lambeth Partnership Delivery Group, the Safer Lambeth Partnership Executive and the Safeguarding Adults Board, however these will not be done in an open forum until after the criminal proceedings and therefore will remain confidential.

A communication plan to be discussed at the September Panel meeting.

12. **Liaison with Home Office**

LB Lambeth to advise of delays in timescales and to maintain contact as necessary.

Jane Ashman

Independent Chair, Domestic Homicide Review Panel, 01/07/13

Appendix 2
GLOSSARY

DHR	Domestic Homicide Review
LBL	London Borough of Lambeth
MPS	Metropolitan Police Services
SCRG	Specialist Crime Review Group (MPS)
SLaM	South London and the Maudsley NHS Foundation Trust
IMR	Internal Management Review
HMP	Her Majesty's Prison
GP	General Practioner
CRI	Crime Reduction Initiatives
PNC	Police National Computer
MHA	Mental Health Act 1983
LEO	Lambeth Early Onset Service
B&B	Bed and Breakfast
PICU	Psychiatric Intensive Care Unit
CPS	Crown Prosecution Service
PI	Public Interest
IDVA	Independent Domestic Violence Advocacy
OASys	Offender Assessment System
SpR	Specialist Registrar
SWT	South West Recovery & Treatment Team
IDAP	Integrated Domestic Violence Programme
OM	Offender Manager
WSO	Women's Safety Officer (Probation)
MARAC	Multi Agency Risk Assessment Conference
SHP	Single Homelessness Project
CSU	Community Safety Unit (Police)
CC	Care Co-ordinator
AMHP	Approved Mental Health Professional
CTO	Community Treatment Order
MAPPA	Multi Agency Public Practioner Arrangements
SPO	Senior Probation Officer
MHTR	Mental Health Treatment Requirement
CTO	Community Treatment Order
CPA	Care Programme Approach
FSW	Forensic Social Worker
RMO	Responsible Medical Officer
DV	Domestic Violence
DI	Detective Inspector
BOCU	Borough Operational Command Unit (Police)

Appendix 3

Home Office

Safeguarding & Vulnerable People Unit

T 020 7035 4848
F 020 7035 4745
www.homeoffice.gov.uk

2 Marsham Street
London

Mr Derrick Anderson and Chief Superintendent Richard Wood
Chairs of Safer Lambeth Partnership
Town Hall
Brixton
London
SW2 1RW

16 June 2014

Dear Mr Anderson, and Chief Superintendent Wood,

Thank you for submitting the report from Lambeth to the Home Office Quality Assurance (QA) Panel. The review was considered at the QA Panel meeting in May.

The QA Panel would like to thank you for conducting this review and for providing them with the Executive Summary, Overview Report, and Action Plan. In terms of the assessment of reports the QA Panel judges them as either adequate or inadequate. It is clear that a lot of effort has gone into producing this report, and I am pleased to tell you that it has been judged as adequate by the QA Panel.

There were some issues that the QA Panel were concerned about and felt would benefit from further consideration before you publish the final report:

- The QA Panel felt that the DHR report should amend the narrative to correct typographical errors and factual inconsistencies;

- The QA Panel felt that some of the text in the Action Plan did not appear to stem from the narrative in the Overview Report. Please align or amend the text in the narrative of the Overview Report to clarify the development of the actions in the Action Plan;

- Please clarify references to the MAPPA arrangements. For example, at paragraph 3.4.9. Please provide more detail to clarify the significance of the reference. For example, what happened and what was done regarding this perpetrator? Also, clarify what court sentence is being referred to in paragraph 3.2.7;

- Some identifiable information is contained in the report such as the address that appears in the report. Please ensure all identifiable references are

removed and the Executive Summary, the Overview Report, and Action Plan are fully anonymised before publication, in accordance with paragraph 73 of the Statutory Guidance for the Conduct of Domestic Homicide Reviews; and,

- The QA Panel also felt that the narrative indicated that the management of perpetrators should have been included in the actions.

The QA Panel also wish to take this opportunity to remind the Police Force involved in this review, that although the Home Secretary announced that from 8 March 2014, the domestic violence disclosure scheme will be implemented across England and Wales, following the successful conclusion of a 1 year pilot in four force areas, powers to disclose where necessary to ensure safety already existed for all forces.

The Domestic Violence Disclosure Scheme was introduced to formalise the process for the existing powers. The Home Office will raise this issue with the College of Policing and the Home Office Oversight Group for the HMIC report on the police response to domestic violence.

The QA Panel also noted the reference in the report to MARAC members being unclear on what information could be shared. The Home Office has noted this as an issue of national relevance and will report this example to Co-ordinated Action Against Domestic Abuse (CAADA) as a training issue.

The QA Panel also noted that the overwhelming majority of the DHR Panel members were from statutory agencies, and felt that it may have benefited from representatives from a voluntary mental health organisation. Your CSP should consider this point when deciding on appropriate DHR panel membership in the future.

Your CSP may also wish to note to assist Chairs we have raised the issue of the Job Centre Plus refusing to submit an Individual Management Review for this DHR. Our colleagues at the Department for Work and Pensions have informed us of a form that Chairs should complete to request disclosure of information they hold. This is available on request to the DHRenquiries@homeoffice.gsi.gov.uk .

The QA Panel does not need to see another version of the report, but I would ask you to include this letter as an appendix to the report when it is published.

Yours sincerely,

Christian Papaleontiou, Acting Chair of the Home Office Quality Assurance Panel
Head of the Interpersonal Violence Team, Safeguarding & Vulnerable Peoples Unit

For more information about this document contact:

Name
Title:
Email:
Phone:

Safer Lambeth Partnership